



CMSC Podcast
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How to Manage an MS Center and Make it Work
Frederick E. Munschauer III, MD

Operator: The conference is now being recorded.

Dr. Frederick Munschauer: Yeah, the questions are just fine. And the--but, the issue is is that you didn't want me to--you know, you have the oral recording of this lecture already up on the website because--.

Ms. Dottie Pfohl: --Okay--.

Dr. Frederick Munschauer: --I've seen it.

Ms. Dottie Pfohl: Yeah.

Dr. Frederick Munschauer: So, this is just really background and filler as it relates to that, right?

Ms. Dottie Pfohl: Exactly. And we do have both the audio portion and your slides, as well as Anne Dunne's, on the website.

But, we are being recorded now, so I want to take like 30 seconds to just get bearings.

Dr. Frederick Munschauer: Yep.

Ms. Dottie Pfohl: And we will start and we'll go from there. And it can be edited, so don't be concerned about that.

Dr. Frederick Munschauer: Yeah, I figured it could because we have David on the other line.

Ms. Dottie Pfohl: There you go. There you go.



Okay, but let's take a breath for even 15 seconds and then I'll start.

I'm Dottie Pfohl, Director of the Consortium of MS Care Website project, and it's my pleasure to welcome you to this podcast.

Our guest is the distinguished neurologist, Dr. Frederick Munschauer, who is-- whose presentation at CMSC annual meeting in Denver drew standing room only crowds. The lecture he co-presented with Ms. Anne Dunne, "How to Manage Your MS Center and Make it Pay," is available to the CMS--on the CMSC website, mscare.org, where you will find an audio and complete lecture, as well as PowerPoint slides.

Dr. Munschauer is a board certified specialist in neurology and internal medicine, with a subspecialty in critical care. He is Irvin and Rosemary Smith Professor and Chair, Department of Neurology, at the State University of New York at Buffalo School of Medicine and Biomedical Sciences, where he serves as Chairman of Neurology as well as Chief of the Jacobs Neurological Institute of Kaleida Health.

He holds many professional memberships, is on the National Board of Directors of the MS Society, and is much beloved for his outstanding service as a member of the CMSC Board of Directors, bringing his business expertise to the office of treasurer.

Dr. Munschauer lectures nationally and internationally on the use of Interferon beta-1a in patients with MS, and is a leader in the field of MS treatment. His interests span vascular disease prevention, healthcare delivery, and MS. He is involved in clinical trials for the NIH as well as industry, and publishes widely.



It is my pleasure to welcome Dr. Rick Munschauer for this podcast. Our goal is to provide the audience with an introduction to the many themes and principles you teach in your lecture on how to manage an MS center and make it pay. And I'm especially proud to share the enthusiasm you inspire. Welcome, Rick.

Dr. Frederick Munschauer: Well, thank you, Dottie. I really appreciate that introduction.

And all of us who are involved in the world of MS know how complicated the care of an MS patient can be, you know, and I think that's why we're attracted to it. People with MS have a whole host of issues that we want to address. And then, you sort of turn the coin and say, gee, we--as a MS practitioner or even at a MS center, whether you're small or big, we still have to keep the lights on and make sure everybody goes home with enough of a paycheck to keep ends meeting.

So, I appreciate the opportunity here to participate in this podcast and give you just some of my thoughts about how we can think a little differently about the MS center and make sure that we don't go broke in the practice of taking good care of people with MS.

Ms. Dottie Pfohl: Well, thank you.

And after listening to the audiotape, our producer commented that this lecture could be considered a business school course. I could promise or warn our listeners that it is so chockfull of information that this--it might be relevant to building and running any



world-class organization. In fact, there is so much useful information that it's more than a little bit intimidating.

And, by the way, I think I mentioned, but the lecture and slides are found on the website. And it could, actually--it will--the actual total lecture runs for an hour and 40 minutes, so we could actually call it an MBA program in an hour and 40 minutes.

Dr. Frederick Munschauer: Well, I think that may be overstating it.

Ms. Dottie Pfohl: Well--.

Dr. Frederick Munschauer: --But, I think we all clearly have the--and what I would like to dispel in this podcast is this concept that there was somehow a compromise between financial solvency and good patient care. I think that one can achieve excellence in patient care and still be able to remain solvent if not have a return on investment that's not only personal but financial.

Ms. Dottie Pfohl: Well, to use your words, it is possible to have an MS center and not go broke, if I remember that. But--.

Dr. Frederick Munschauer: --You have to be a little creative, but it is.

Ms. Dottie Pfohl: There you go.

Recognizing, though, that people with MS have unique and many needs. I wouldn't say needy but full of needs, and that their care can be intense and continue over long periods of time. Why do you think making MS--the elements of an MS center work and pay is such a fundamental challenge, and even a novel idea?



Dr. Frederick Munschauer: Well, I think part of it has to do with really a distribution of efforts, and I think we'll talk about that. In a traditional neurologist's office, you will introduce a patient to your room and the patient will then tell you a whole host of difficulties they're having with life. Some of them are medical, some of them are emotional, some of them are psychosocial. And in the traditional model, the neurologist felt that he needed to take care of all of them. And maybe if he had a nurse that he could bring in or if he had someone else in his office that could help share the burden of taking care of this person, the neurologist might occasionally utilize them.

But, principle number one in an effective MS center is to be able to assemble a group of people that will allow the neurologist to really address the medical portion of somebody with multiple sclerosis and bring in the appropriate resources quickly to address the other multifaceted needs of somebody with MS.

Ms. Dottie Pfohl: Well, and, you know, among the centers in the MS--CMSC and certainly in my town, Philadelphia, there's tremendous diversity in types of care and places where patients get their care, but the centers differ so widely in size and goals and roles. You describe an approach of--to strategically assessing and taking an inventory that seems to work for organizations big and small. How did you come to this insight [unintelligible]?

Dr. Frederick Munschauer: Dottie, you're quite right. I am fortunate to be associated with a fairly large MS center where we have a number of neurologists who



take care of people with MS, and also have nurse practitioners, nurses, nursing assistants, as well as even a social worker.

But, that was put together over time just starting small and working large. But, the average MS center is a neurologist in the community who sees MS patients a half a day a week or maybe two half days a week, and may or may not have a nurse that's associated with the general neurology practice that they're involved with.

So, I think that I would like to really disabuse the listeners of the concept that in order to make an MS center pay, you have to be seeing 3,000 MS patients a year and have 15 to 20 staff members. It can begin very simply.

For instance, if a practitioner would concentrate all of his MS patients in a given morning or afternoon, then you can really bring a whole host of resources to that clinic, and it is a much more effective and efficient way of seeing MS patients than to say you're going to see an MS patient followed by a Parkinson's patient followed by a migraine patient followed by an epilepsy patient. We have found that by just concentration of MS patients in certain blocks of time that we're able to improve the efficiency, and with the efficiency, the quality of care also goes up.

So, I hear your point, Dottie, that, you know, MS centers may offer a huge variety of resources, and that is indeed true. But, I think you have to start by leveraging with your strengths. For instance, there's an MS center in my town other than my MS center that is very integrated with a physical therapy department, and they have a physiatrist on



site. Well, that MS center tends to concentrate on people with more disabilities, and the neurologist and the physiatrist work hand in hand to try to augment care and improve quality of care.

So, it really--you know, it's like all politics is local. MS care, in a way, can be local when you begin to look around and see what resources you can bring to the care of an MS patient with little expense.

Ms. Dottie Pfohl: And the principle applies to the smallest to the largest centers. They seem to have overlap.

Dr. Frederick Munschauer: Absolutely, Dottie.

Ms. Dottie Pfohl: Well, I love your concept of value added, those little things that make a center great. And perhaps as testimony to your expertise as a leader, you suggest that people first ask themselves what they need the most. How did a neurologist develop this kind of a business sense?

Dr. Frederick Munschauer: Well, probably necessity is the mother of invention. And I would absolutely not claim that we have it figured out in Buffalo. We've got a lot of people thinking about it in a very creative way.

But, I've also had the opportunity to listen to some best practice opportunities and best practice patterns from around the country, and several of them make really very good examples. For instance, clearly you improve the quality of care in somebody with MS if you have access to ancillary services. Let me just pick one, MRI.



Well, certainly I'm not saying that every individual practice needs to own an MRI. But, if you develop a relationship with a specific MRI center and you establish protocols with that center, then an MS center then can improve the quality of care and also improve the efficiency of referral of patients to given providers such as an MRI center or maybe a physical therapy center or infusions therapy or psychiatry or a physiatrist. And you can, by establishing those relationship in a organized rather than a haphazard way, improve the efficiency of how you see MS patients as well as the quality of care.

And it does--in our particular center we actually don't need more patients. We have all the patients we can handle. In our particular center, what we needed to do was to improve the services that we give to each one of our patients without necessarily encumbering the neurologist or the advanced practice nurses in more ancillary kinds of activities that would take them away from the thing they do best, and that's evaluate the medical aspects of therapy.

Everybody needs more money, that's for sure. Some people may need more administrative support and recognition. There's an MS center in North Carolina that secured a substantial amount of Stark compliant hospital support in terms of the medical director simply because that medical director was able to prove to the hospital that, by having an MS center, that hospital increased revenues in terms of MRI and in terms of physical therapy. And another intangible, that MS center was one of the few in North Carolina that did a extraordinarily sophisticated clinical research and clinical trials in MS, and had become known as a center for advanced pharmaceutical interventions in people



with MS. And when that MS center director made his case clearer to administration, financial support followed along and made that center financially viable.

So, I think it's--I think being able to find these kinds of strategic relationships and also to communicate a concept that the value of your MS center extends so far beyond just an initial patient visit, but that it can also advance the--it can advance the mission of the practice or the hospital system or university that you're involved with. And doing that kind of strategic assessment, I think, is very important to trying to find other sources of support for your MS center other than the clinical visit.

Ms. Dottie Pfohl: Well, I do remember a site in Washington state, I believe, that was really not being too well treated until they used an approach like this to show how valuable they were to the institution, and they wound up getting additional space. So, I think there is precedent for that. Is that what you mean by internal and external connections or networking?

Dr. Frederick Munschauer: Yes, it is, and I think that's a good point. I--you know, most of the time we're so busy with what is urgent and what is important, like taking care of the patient in front of us, we don't really spend enough time trying to figure out ways of working smarter. And I would just recommend to anybody considering forming an MS center to begin to look at the resources around them that would facilitate both improved patient care, if your specific need is more patients, improved referrals for more patients, or somehow add to the value equation of both the MS center and the



underlying patient, and I've broken that down to what we call internal and external connections.

And a true MS center is really a center without walls where you, as a person trying to design a more optimal MS center, should take some time and begin to pick within the community those resources that could help you. Probably the best example is that the MS Society in our area has a social worker. We have been able to get that social worker to come to our clinic two half days a week when we see MS patients and MS patients that may have rather profound psychosocial problems.

Now, we don't pay for that social worker, the MS Society does. That MS Society social worker goes to two or three other clinics, she just happens to come to ours at one particular day. What that does for the neurologist is the neurologist can say, "Okay, I can't go into this problem that you have now, but I have a social worker here and she would be glad to help you with that." And for insurance issues as well as access to care and access to durable medical goods and disability kinds of things, that's very important.

Similarly, we have a psychiatrist that we have identified in the community who's interested in taking care of psychiatric disturbance in people with MS. And by referring to that person consistently, we make headway. People with MS frequently have poor dentition, a dentist. Particular occupational, physical, and speech therapists that really specialize in MS can be identified in the community.

And when you begin to structure these kinds of relationships with the preferred providers, and they can range, you know, from all disciplines of medicine, then you begin



to create a center of excellence where you can also make sure that people get the appropriate referrals.

So, that's what I mean by internal connections, and making those internal connections with an MS center improves both efficiency and the quality of care, and it really comes up to be a win-win basis. It may get you to see an extra two or three patients per day or go home an hour earlier. It's not going to make you a great deal of money.

Ms. Dottie Pfohl: Well, that's what I'm wondering, Rick, is that what, though, does bring in revenue? Because I know that we've talked about a preconception or a misconception, I'm not sure which, that clinic visits are the only revenue source.

Dr. Frederick Munschauer: That's correct. And that is the preconception, and that is not true. An MS center can provide a number of what I refer to as lines of business that are revenue generating that are strictly compatible with quality of care without a feeling that we're any way fleecing the system.

Let me give you some examples of that, and they range from the simple to the complicated. Let me take a simple example. One of them is bladder ultrasound. We have found that bladder ultrasound in our clinic is extremely helpful for us determining whether somebody needs a urologic referral. If somebody has two urinary tract infections within a year and they have a bladder ultrasound that shows that they have more than 50 to 75 CCs of retention post-void, well, we know that person is in trouble. Sometimes, if you give them an anticholinergic drug and they may go into more acute



urinary retention, we can find that out. And Medicare and Medicaid pay for bladder ultrasound in a way that is--represents a pattern of reimbursement unfortunately similar to a level 3 visit.

Now, we don't do bladder ultrasound on everybody but, you know, we do do it two or three times a day. Other centers around the country do ocular computed tomography. There are certainly centers that are associated with physical therapy, and a patient would not only see a doctor on one visit but then would also go see the physical therapist, and the physical therapist and the physician have some sort of a business model.

We do have an MRI machine associated with our university-based practice where the neurologists in our group actually read the images. That is a line of business that can be accentuated.

Another one that I think is very helpful is clinical research. I--small practices that have 50 or more MS patients certainly can get involved in clinical research. Now, gone are the days where you can do clinical research and make hundreds of thousands of dollars. But, with us, the clinical research is enough to support a nurse full-time, but she doesn't work on the project necessarily full-time. The other half time, she's in our clinic helping us out, seeing patients more effectively.

So, I do believe that these--you know, these lines of business are absolutely ways in which you can increase revenues. Infusion centers is the one that is probably most



popular now for MS practices. You do not have to run an infusion center with 10 chairs five days a week. Very commonly, people have infusion centers that are run by a per diem nurse, somebody who is sort of on the mommy track, usually. And they come in Monday and Wednesday afternoons and do four or five infusions each day with two or three chairs, and those rooms are used for other uses in other days of the week.

And infusion centers like that, if they're appropriately managed, are revenue generators. Some medications you'd earn more money on than others. The most lucrative by far is IVIG. It's also now the most difficult to get insurance approvals for. We use a large amount of Natalizumab in our practice, only about 15 percent of our MS patients. That is a revenue generating process for us. And the revenues that are generated from that go right back in to support the MS center.

So, those are the kinds of mundane lines of business that an MS center can add to be more financially responsible.

Ms. Dottie Pfohl: I have learned so many new terms from you, like payer mix. What the heck is a payer mix?

Dr. Frederick Munschauer: Well, that is really--and when you talk about infusion centers, that's important, too.

A payer mix is just what percentage of your patients have insurance that falls into several buckets. A bucket can be Medicare, it can be Medicaid, it can be uninsured, it can be a HMO type of insurance, the managed care insurance, or it can be a more



traditional fee-for-service kind of approach. And the payer mix, then, will determine your revenues.

Basically, we feel that--we see Medicaid patients, but we get paid \$16 for a Medicaid visit and it costs us probably \$24. So, on every Medicaid patient we see, we lose money on. But, our mission, at a university hospital, is to see everybody.

With Medicare, which is most parts of the country is probably the least well-reimbursed line, well, we can make money, particularly on these ancillary services that we see. And we can do--by more effective documentation, billing, and coding, we can reflect that the level of our service to Medicare patients and to HMO patients would warrant billing at a higher level such as level 3--as having more level 4 visits than level 3 visits, and a few level 5 visits for follow ups.

The reimbursement difference between 3 and 4 is usually about 15 percent. The reimbursement difference a level 4 and a level 5 visit is 50 percent. So, it really is very important to make sure that you document and bill according to the level of your services. And that's an art. That takes people in your clinic looking at what you're doing, looking at your documentation, looking at your billing, and making sure that what you do matches what you document and what you document reflects the level at which you bill at.



That's true in all branches of neurology. And practice efficiency is predicated upon having an infrastructure within your own particular practice setting that allows you to make those determinations efficiently.

Ms. Dottie Pfohl: Well, I know you really stress the importance, the crucial aspect that documentation plays to the survival and success of a practice. But, I'm also really impressed by your insistence that you understand exactly what each time members--team members time is worth so that you can mask--match the person suitably to the task. Because I know when I sat in on your lecture at Annual Meeting, few people in the audience, and most of us were healthcare providers, could tell you what their market share was or how much each minute of their time was worth.

Dr. Frederick Munschauer: Yeah, you know, it's really true is that--you know, if you just, you know, do the math. If the average neurologist makes between \$150,000 and \$200,000 a year, and that is about the average in the Northeast for a neurologist in private practice. God, I hope a lot of neurologists make more than that, but I know a lot make less.

Ms. Dottie Pfohl: And have a large number of salaries riding on them.

Dr. Frederick Munschauer: You really do. And so, for--what the neurologist may forget is that when the neurologist says, "Oh, I'll just do it myself because I can do it quicker," and he gets on the phone and does the prior approval or he goes to the Xerox machine and Xeroxes something, or he decides that he is going to, in some way--you know, "The chart is a mess and I'm just going to fix it myself because it won't get done."



If the neurologist recognizes that they are, you know--essentially, if you back it out, a neurologist should be worth about \$6 a minute. And you could very nicely have the neurologist be more focused on actual medical issues and allow, you know, people being paid a much lower pay rate do those tasks that are somewhat more elemental. I don't want to call them menial because there's nothing about medicine that's menial. But, there are some that are more elemental and some that are more strategic or tactical.

Ms. Dottie Pfohl: No, but you have a couple of slides that really, I think, are priceless. And one is the organizational chart for the center and--showing the common with a unique way of organizing thoughts.

You also have a matrix that, to me, is fascinating, of urgent and non-urgent, and I'm really not quite sure how to use it. But, when I was looking at things I thought how much of the time goes to some of the matrix and how little for the very suggestions that would make the entire center run smoother.

Dr. Frederick Munschauer: Well, it's really true. And I must admit I borrowed this from Stephen Covey's book, 7 Habits of Highly Effective People. The processes here is that it's--you know, we all live in doing what we feel, at any one time, is both important and urgent. And a lot of the times, we just do things that are urgent but not important like, you know, somebody calling you up and--you know, and interrupting you in the middle of the day to sell you cable service, you know, on your cell phone.



And the moral of the story is we all, whatever discipline you're in, spend too little time thinking about what is important but not necessarily urgent. And carving out that time is one of the principles of time management that I think Stephen Covey really reflects well.

I also think, too--I mean, I visited a wonderful MS center in Raleigh, North Carolina that illustrated another one of these organizational issues that I thought was extremely well done. And that is that if you're at a traditional MS center and you're a doc and you have an issue, you want somebody to take care of a problem that you have so that you can talk to the patient, if you walk out there and grab just any person who happens to be in your vicinity such as a nurse or an LPN or a secretary to do something for you, you end up having kind of an organizational chaos. And the best practices, I think, are done very efficiently.

This practice in Raleigh, North Carolina is the doctor has a nurse or an LPN and a secretary that is assigned to that particular physician's clinic. If the physician doesn't have to be in clinic that half day, they're with other people. But, as a result, that doctor can--establishes a linear kind of relationship with the support staff that allows him to be much more effective than if he was--than if all the people in a busy clinic could relate to all the doctors.

That probably doesn't happen in very small private practice neurology groups or clinics but, gee, it does in the big ones. When you have five or six neurologists in a practice and you have--you know, the average neurologist has about 2.3 support staff for



every neurologist. Cardiologists have eight. Ophthalmologists have 11. So, neurologists are generally understaffed when it comes to support staff. But, in general, you know, if you relate to the same people and they learn the technicalities of your individual practice well, that improve your efficiency, too.

Ms. Dottie Pfohl: Well, I know that we've surveyed the CMSC membership. But, I'm wondering how can we at CMSC support new centers or those that need to rethink their approach to caring for people with MS?

Dr. Frederick Munschauer: That's a very good question, Dot. And I think there are a lot of neurologists, a lot of advanced practice nurses, who love their MS patients. And they feel that they would do more MS if, you know, there was some way that they could make a living doing it.

And I think that the CMSC can help, and one of the things that's happening within the CMSC is we're trying to develop a mentoring program where one center that is well-established can speak specifically to a smaller center and help them along in this process development so that they don't make the same mistakes that the larger center has made on their way of getting there. And I think more courses in practice management would help.

There are some other techniques, in closing, that we haven't talked about. And these are really sort of thinking out of the box a little bit that I think it would be important to emphasize, and they relate more to this concept of external connections. At our center, it really got its start by grateful patients making donations. So, what we had to do, which was out of the box 10 years ago, now it's done in many other centers, is we established,



within a foundation, it happened to the foundation of our hospital, a fund that would be a vehicle to support philanthropic kinds of donations. And although I, as a physician, never asked patients for money, the development group within our Jacobs Neurologic Institute does send out just notices of people, you know, what's going on in MS, a newsletter, and with it there's also a donation card. And, you know, we get about \$15,000, \$20,000 a year just from grateful patients.

We have been able to secure some larger gifts from people who we've actually never taken care of but who MS has affected them. And we do have a fundraiser once a year. Ours is called Jog for the Jake, but other people have golf tournaments and luncheons and--oh, there was one MS center that even had one of these mystery murder theaters in a restaurant. You had to figure out who did it.

Ms. Dottie Pfohl: I might just stop you for a second, just to mention that the Jake we're speaking of is the beloved Dr. Jacob.

Dr. Frederick Munschauer: That's right. That's right, Jog for the Jake was Dr. Jacob.

Ms. Dottie Pfohl: For whom the institute is named, yes.

Dr. Frederick Munschauer: Yeah, it's a Father's Day run.

But, there are many of those that are done. And I would recommend that a MS center work with a foundation to set up some sort of a philanthropic support for the institution. And you know what? We have found that local foundations are very interested in supporting activities that relate to access to healthcare or durable medical



equipment. We had one foundation who gave us \$20,000 for a fund called Because We Care, which is just a fund that we have that gives out money to people who can't pay their power bill who have MS, or need another two weeks of their Baclofen prescription so that they don't run out of it, things like that.

And that's part of that. We've had various--very generous donations to our foundations from, for instance, home healthcare providers. So, we have a external referral to one particular home healthcare company that's a for-profit company. Each year, the foundation asks for a philanthropic gift to--from that home care company to the foundation. And you know what? It's all--this is not a kickback. It's--we don't use that money to support the salaries of the physicians. There are--none of those monies go to direct care, but they help in the infrastructure of running the department and they help our particular neurologists when they want to do a little project that is involved in multiple sclerosis care, or a nurse who wants to do a project. And it turns out to be a win-win kind of situation.

So, I would recommend that people begin to think of MS as a total care issue, not just a means for generating a consult equivalent in terms of revenue, because some of the more altruistic or research kinds of activities or philanthropic activities really make an MS center more efficient, more effective, and, you know, the neurologist gets to keep a little bit more of what he makes.

Ms. Dottie Pfohl: Well, speaking of win-win, Dr. Munschauer, you've given us so much valuable information. Thank you.



Dr. Frederick Munschauer: Thank you, Dottie. I've enjoyed it.

Ms. Dottie Pfohl: Well, there's just not enough time in one session to cover all we'd like, but we trust that this discussion will continue.

The full audio and slides of Dr. Munschauer's lecture along with Anne Dunne, who co-presented with him at Annual Meeting, "How to Set Up an MS Center and Make it Pay," are available at mscare.org.

A special thanks to our speakers, Dr. Munschauer particularly, our producer, David Kettihenrick [sp], web project manager Rachelle Ramirez, and of course, June Halper [sp] and the staff of the CMSC. Thank you.